Health Care Financing

RESEARCH BRIEF

These brief reports from the Office of Research, Office of Research and Demonstrations, provide program information on current health care issues.

They are based on data from the Medicare statistical files developed and maintained by the Bureau of Data Management and Strategy, Health Care Financing Administration.

Health Care Financing Administration
Office of Research & Demonstrations

Hospital Outpatient Services Under Medicare: Trends and Demographic Variations, 1983

Hospital Outpatient Services Under Medicare: Trends and Demographic Variations, 1983

This report presents 1983 data on the use and cost of hospital outpatient (HOP) services rendered to aged and disabled supplementary medical insurance (SMI) beneficiaries. Among the services covered by Medicare, reimbursements for HOP services have shown the largest rate of increase since the inception of the program. Between 1974 and 1983, Medicare reimbursements for HOP benefits increased from $0.5 billion to $3.8 billion, an average annual compound growth rate of 24 percent. Similarly, during the same period, short-stay hospital inpatient expenditures showed an average annual growth rate of 17.8 percent.

With the advent of the Medicare prospective payment system (PPS), the growth of HOP services is expected to accelerate even more. The purpose of this report, therefore, is to provide baseline data for comparing the use of HOP services before and after the implementation of PPS. The new legislation, which went into effect on October 1, 1983, radically restructured the payment system in which short-stay hospitals are reimbursed for inpatient services provided to Medicare beneficiaries. The PPS, thereby, is expected to produce a shift from traditional inpatient hospital care towards more liberal use of outpatient services than ever before under Medicare. For example, because of PPS and technological advances, the cataract procedure is being done more on an outpatient basis at a hospital or doctor's office. According to a recent study (The Medicare Case Mix Index Increase - June 1985) prepared and released by the Rand Corporation, the proportion of Medicare discharges incurring a lens procedure in a short-stay hospital dropped from 3.95 percent in fiscal year 1983 to 3.52 percent in fiscal year 1984.

Other types of surgery performed regularly on an inpatient basis are, also, now probably being done more on an outpatient basis. In addition, many admissions to inpatient acute care hospitals are probably being reviewed with greater discretion to determine whether outpatient services are a viable option. It is hoped that the anticipated larger use of HOP services and the lesser use of inpatient facilties will maintain the quality of patient care, and, at the same time, effect a slowing in spiraling Medicare expenditures.

The report focuses on covered charges, reimbursements, covered charges per enrollee, and reimbursements per enrollee as a means of measuring the cost of HOP services. The data are classified by selected calendar years 1974 thru 1983 (Table 1); sex, race, and type of entitlement by type of service (Table 2); sex, race, and type of entitlement by clinic and emergency room services (Table 3); and residence of the beneficiary by type of entitlement (Tables 4 and 5). Other reports will be available in the near future to identify and monitor the expected rapid growth in the use of HOP services.

This report was prepared in the Division of Program Studies of the Office of Research. For additional information regarding this report, or for suggestions regarding future topics, please call Vikki Latta at (301)597-1438 or FTS 987-1438.

Selected Data Highlights

Table 1 - Trends

- Between 1974 and 1983, covered charges for hospital outpatient (HOP) services to Medicare beneficiaries increased more than sevenfold, rising from $0.5 billion to $3.8 billion, an average annual compound growth rate of increase of 24 percent.

- Reimbursements for HOP services increased even more rapidly, going from $0.3 billion in 1974 to $2.7 billion in 1983, an average annual rate of increase of 26 percent. This reflects the fact that reimbursements, as a percent of covered charges, rose from 60.4 percent in 1974 to 69.8 percent in 1983.

- The average amount reimbursed per enrollee increased from $13.96 in 1974 to $91.85 in 1983.

Table 2 - Type of Service Charges

- HOP charges for radiology services ($0.8 billion) and laboratory services ($0.7 billion) accounted for nearly two-fifths of all HOP charges for Medicare beneficiaries. The "other" category (which includes charges for dialysis services, computerized axial tomography, durable medical equipment, blood administration, ambulance services, etc.) accounted for another 40 percent of the total charges.

- There were substantial differences by race and type of entitlement in the charges per enrollee for HOP services. The total charge per enrollee for persons of all other races ($206) was 66 percent higher than that for persons of the white race ($124). The total charge per disabled enrollee ($161) was 41 percent higher than that for the aged ($114). These differences were reflected, for the most part, in the use of clinic services.

Table 3 - Use and Charges of Clinic and Emergency Room Services

- The use of clinic services (204 visits per 1,000 enrollees) and emergency room services (206 visits per 1,000 enrollees) was nearly the same under the Medicare program. The charge for these services was also nearly the same ($44 per visit and $46 per visit, respectively).

- There were, however, substantial differences in the use (number of visits per 1,000 enrollees) of clinic and emergency room services by race and type of entitlement. Disabled beneficiaries used clinic services and emergency room services at a rate 2.9 times and 2.1 times greater, respectively, than the aged. Persons of all other races used clinic services and emergency room services at a rate 4.9 times and 1.4 times greater, respectively, than persons of the white race.

Table 4 - Reimbursement by Residence of Aged Beneficiaries

- The average HOP reimbursement per aged enrollee in the United States was $79.
- By region, the average HOP reimbursement per enrollee was highest in the West ($97) and lowest in the South ($59). By State, Massachusetts ($152) and the District of Columbia ($134) had the highest average reimbursement per enrollee. South Dakota ($38) and Tennessee ($46) had the lowest average among all States.

Table 5 - Reimbursement by Residence of Disabled Beneficiaries

- The average HOP reimbursement per disabled enrollee in the United States, excluding those with ESRD, was $116. This was 47 percent more than the average for the aged ($79).
- By region, the average reimbursement per enrollee ranged from $159 in the West to $81 in the South. By State, the average ranged from $254 in Massachusetts to $28 in South Dakota.

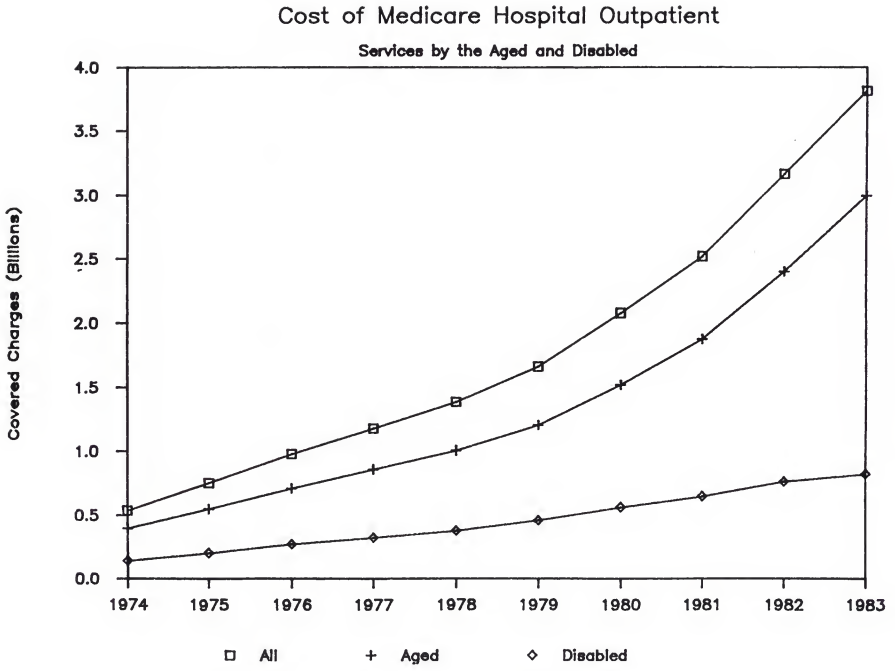
Cost of Medicare Hospital Outpatient
Services by the Aged and Disabled
Covered Charges (Billions)
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
All
Aged
Disabled

TABLE 1

USE OF MEDICARE HOSPITAL OUTPATIENT SERVICES BY THE AGED AND DISABLED: COVERED CHARGES AND REIMBURSEMENTS: 1974 - 1983

YEAR SERVICE INCURRED 1/	NUMBER OF ENROLLEES	COVERED CHARGES IN THOUSANDS	REIMBURSEMENTS		
			AMOUNT IN THOUSANDS	PER ENROLLEE	AS PERCENT OF CHARGES
ALL BENEFICIARIES					
1974	23,166,570	$535,296	$323,383	$13.96	60.4
1975	23,904,551	747,518	469,875	19.66	63.0
1976	24,614,402	974,708	630,323	25.61	64.7
1977	25,363,468	1,175,878	773,490	30.50	65.8
1978	26,074,085	1,384,067	923,658	35.42	66.7
1979	26,757,329	1,660,358	1,132,202	42.31	68.2
1980	27,399,658	2,076,396	1,441,986	51.75	69.4
1981	27,941,227	2,521,191	1,777,255	63.61	70.4
1982	28,412,202	3,164,530	2,203,260	77.55	69.6
1983	28,974,535	3,813,118	2,661,394	91.85	69.8
PERCENT CHANGE, 1974 - 1983	25	612	723	558	16
AGED					
1974	21,421,545	394,680	220,742	10.30	55.9
1975	21,948,301	546,095	323,563	14.74	59.3
1976	22,445,911	704,569	432,971	19.29	61.5
1977	22,990,026	855,412	540,040	23.49	63.1
1978	23,530,893	1,005,467	648,249	27.55	64.5
1979	24,098,491	1,203,048	797,442	33.09	66.2
1980	24,680,432	1,517,183	1,030,896	41.77	69.9
1981	25,181,731	1,874,136	1,300,040	51.63	69.3
1982	25,706,792	2,402,462	1,645,064	63.99	68.5
1983	26,292,124	2,995,784	2,066,207	78.59	69.0
PERCENT CHANGE, 1974 - 1983	23	659	836	663	23
DISABLED					
1974	1,745,019	140,617	102,641	57.07	70.8
1975	1,959,248	201,423	146,312	74.69	72.6
1976	2,168,467	270,139	197,352	91.03	73.1
1977	2,372,594	320,466	233,450	98.38	72.8
1978	2,543,162	378,600	275,409	108.29	72.7
1979	2,658,838	457,315	334,760	125.90	73.2
1980	2,719,226	559,213	411,090	151.55	73.5
1981	2,759,496	647,054	477,215	172.94	73.7
1982	2,705,490	762,068	558,195	206.32	73.2
1983	2,682,411	817,335	595,187	221.89	72.8
PERCENT CHANGE, 1974 - 1983	54	481	480	289	3

1/ 1974 - 83 FIGURES BASED ON DATA RECORDED ONE YEAR AFTER THE SERVICE WAS INCURRED

TABLE 2

USE OF MEDICARE HOSPITAL OUTPATIENT SERVICES BY THE AGED AND DISABLED: COVERED CHARGES, PERCENT DISTRIBUTION, AND AVERAGE CHARGE PER ENROLLEE BY TYPE OF SERVICE, SEX, RACE, AND TYPE OF ENTITLEMENT: 1983

SEX, RACE, AND TYPE OF ENTITLEMENT	TOTAL	CLINIC	EMERGENCY ROOM	LABORATORY	RADIOLOGY	PHARMACY	PHYSICAL THERAPY	OTHER 1/
CHARGES			(IN THOUSANDS)					
TOTAL	$3,813,110	$261,173	$273,784	$691,021	$800,496	$100,752	$156,474	$1,529,592
SEX								
MEN	1,710,033	104,881	123,282	290,396	343,368	48,832	56,864	742,642
WOMEN	2,103,084	156,292	150,502	400,624	457,128	51,919	99,610	786,949
RACE								
WHITE	3,143,317	163,248	226,539	575,889	701,319	87,175	137,760	1,251,288
ALL OTHER	569,030	91,731	40,693	95,968	77,975	10,278	14,625	237,699
UNKNOWN	100,769	6,193	6,551	19,162	21,201	3,299	4,088	40,605
TYPE OF ENTITLEMENT								
AGED	2,995,703	192,094	224,359	566,763	714,884	80,902	132,758	1,084,380
DISABLED 2/	430,902	64,240	46,793	80,185	77,828	12,807	22,501	126,425
PERCENT DISTRIBUTION								
TOTAL	100.0	6.8	7.2	18.1	21.0	2.6	4.1	40.1
SEX								
MEN	100.0	6.1	7.2	17.0	20.1	2.9	3.3	43.4
WOMEN	100.0	7.4	7.2	19.0	21.7	2.5	4.7	37.4
RACE								
WHITE	100.0	5.2	7.2	18.3	22.3	2.8	4.4	39.8
ALL OTHER	100.0	16.1	7.2	16.9	13.7	1.8	2.6	41.8
UNKNOWN	100.0	6.1	6.5	19.0	21.0	3.3	4.1	40.3
TYPE OF ENTITLEMENT								
AGED	100.0	6.4	7.5	18.9	23.9	2.7	4.4	36.2
DISABLED 2/	100.0	14.9	10.9	18.6	18.1	3.0	5.2	29.3
CHARGES PER ENROLLEE								
TOTAL	$131.60	$9.01	$9.45	$23.85	$27.63	$3.48	$5.40	$52.79
SEX								
MEN	140.66	8.63	10.14	23.89	28.24	4.02	4.68	61.09
WOMEN	125.05	9.29	8.95	23.82	27.18	3.09	5.92	46.79
RACE								
WHITE	123.76	6.43	8.92	22.67	27.61	3.43	5.42	49.27
ALL OTHER	206.39	33.27	14.76	34.81	28.28	3.73	5.30	86.22
UNKNOWN	122.89	7.55	7.99	23.37	25.86	4.02	4.99	49.52
TYPE OF ENTITLEMENT								
AGED	113.94	7.31	8.53	21.56	27.19	3.08	5.05	41.24
DISABLED 2/	160.66	23.95	17.45	29.90	29.02	4.78	8.39	47.14

1/ THE "OTHER" CATEGORY INCLUDES CHARGES FOR COMPUTERIZED AXIAL TOMOGRAPHY, DURABLE MEDICAL EQUIPMENT, BLOOD ADMINISTRATION, DIALYSIS SERVICES, AMBULANCE SERVICES, ETC.
2/ EXCLUDES ALL PERSONS UNDER AGE 65 WITH END-STAGE RENAL DISEASE.

TABLE 3

USE OF MEDICARE HOSPITAL OUTPATIENT CLINIC AND EMERGENCY ROOM SERVICES BY THE AGED AND DISABLED: VISITS AND CHARGES BY SEX, RACE, AND TYPE OF ENTITLEMENT: 1983

SEX, RACE, AND TYPE OF ENTITLEMENT	CLINIC SERVICES				EMERGENCY ROOM SERVICES			
	VISITS		CHARGES		VISITS		CHARGES	
	NUMBER IN THOUSANDS	PER 1,000 ENROLLEES	AMOUNT IN THOUSANDS	PER VISIT	NUMBER IN THOUSANDS	PER 1,000 ENROLLEES	AMOUNT IN THOUSANDS	PER VISIT
TOTAL	5,900	204	$261,173	$44.27	5,959	206	$273,784	$45.94
SEX								
MEN	2,366	195	104,881	44.33	2,637	217	123,282	46.75
WOMEN	3,534	210	156,292	44.23	3,323	198	150,502	45.29
RACE								
WHITE	3,759	148	163,248	43.43	5,032	198	226,539	45.02
ALL OTHER	1,985	720	91,731	46.21	780	283	40,693	52.17
UNKNOWN	155	189	6,193	39.96	147	179	6,551	44.57
TYPE OF ENTITLEMENT								
AGED	4,478	170	192,094	42.90	4,843	184	224,359	46.33
DISABLED 1/	1,345	501	64,240	47.76	1,055	393	46,793	44.35

1/ EXCLUDES ALL PERSONS UNDER AGE 65 WITH END-STAGE RENAL DISEASE.

TABLE 4

USE OF MEDICARE HOSPITAL OUTPATIENT SERVICES BY THE AGED: COVERED CHARGES AND REIMBURSEMENTS, BY RESIDENCE: 1983

AREA OF RESIDENCE	COVERED CHARGES IN THOUSANDS	TOTAL REIMBURSEMENTS		
		AMOUNT IN THOUSANDS	PER ENROLLEE 1/	AS PERCENT OF CHARGES
ALL AREAS	$2,995,784	$2,066,207	$78.59	69.0
UNITED STATES 2/	2,987,620	2,061,238	79.11	69.0
NORTHEAST	886,588	568,107	92.24	64.1
NORTH CENTRAL	787,437	551,884	80.42	70.1
SOUTH	723,823	505,438	59.17	69.8
WEST	589,772	435,809	97.41	73.9
NEW ENGLAND	261,371	185,921	119.38	71.1
CONNECTICUT	47,418	34,821	90.47	73.4
MAINE	27,293	14,067	95.81	51.5
MASSACHUSETTS	148,464	110,717	152.16	74.6
NEW HAMPSHIRE	15,217	11,003	101.69	72.3
RHODE ISLAND	15,669	10,098	78.03	64.4
VERMONT	7,309	5,215	86.36	71.3
MIDDLE ATLANTIC	625,217	382,186	83.06	61.1
NEW JERSEY	88,393	63,660	71.36	72.0
NEW YORK	276,876	159,431	74.82	57.6
PENNSYLVANIA	259,948	159,095	100.78	61.2
EAST NORTH CENTRAL	572,941	399,441	86.20	69.7
ILLINOIS	161,960	107,704	84.70	70.9
INDIANA	54,945	39,782	66.11	72.4
MICHIGAN	173,726	113,538	117.83	65.4
OHIO	130,029	93,908	77.83	72.2
WISCONSIN	62,273	44,509	75.37	71.5
WEST NORTH CENTRAL	214,496	152,443	68.40	71.1
IOWA	38,654	27,783	70.29	71.9
KANSAS	36,788	27,277	88.23	74.1
MINNESOTA	48,774	34,948	70.56	71.7
MISSOURI	61,904	43,390	67.28	70.1
NEBRASKA	15,879	11,269	54.30	71.0
NORTH DAKOTA	7,290	4,243	50.69	58.2
SOUTH DAKOTA	5,209	3,533	38.06	67.8
SOUTH ATLANTIC	427,361	300,381	67.46	70.3
DELAWARE	8,323	4,519	71.28	54.3
DIST. OF COLUMBIA	11,549	8,756	133.87	75.8
FLORIDA	154,868	115,883	67.80	74.8
GEORGIA	50,410	35,069	66.56	69.6
MARYLAND	48,657	32,634	81.45	67.1
NORTH CAROLINA	50,169	33,947	53.70	67.7
SOUTH CAROLINA	25,707	17,201	57.46	66.9
VIRGINIA	54,866	39,440	76.30	71.9
WEST VIRGINIA	22,811	12,932	54.17	56.7

SEE FOOTNOTES AT END OF TABLE

TABLE 4 (CONTINUED)

USE OF MEDICARE HOSPITAL OUTPATIENT SERVICES BY THE AGED: COVERED CHARGES AND REIMBURSEMENTS, BY RESIDENCE: 1983

AREA OF RESIDENCE	COVERED CHARGES IN THOUSANDS	TOTAL REIMBURSEMENTS		
		AMOUNT IN THOUSANDS	PER ENROLLEE 1/	AS PERCENT OF CHARGES
EAST SOUTH CENTRAL	117,786	82,479	49.76	70.0
ALABAMA	34,585	24,748	56.23	71.6
KENTUCKY	27,798	19,160	46.63	68.9
MISSISSIPPI	20,488	14,469	51.10	70.6
TENNESSEE	34,915	24,103	46.06	69.0
WEST SOUTH CENTRAL	178,676	122,577	50.39	68.6
ARKANSAS	20,636	14,686	47.34	71.2
LOUISIANA	30,826	21,120	55.94	68.5
OKLAHOMA	28,360	17,451	47.62	61.5
TEXAS	98,854	69,321	50.29	70.1
MOUNTAIN	132,227	94,177	82.91	71.2
ARIZONA	36,241	25,986	78.66	71.7
COLORADO	32,114	22,362	86.67	69.6
IDAHO	12,245	8,803	86.77	71.9
MONTANA	10,737	7,850	86.47	73.1
NEVADA	11,176	7,891	102.46	70.6
NEW MEXICO	13,938	9,964	81.30	71.5
UTAH	12,050	8,738	75.36	72.5
WYOMING	3,727	2,583	65.07	69.3
PACIFIC	457,545	341,632	102.35	74.7
ALASKA	1,928	1,279	104.95	66.3
CALIFORNIA	370,133	280,085	113.33	75.7
HAWAII	9,101	6,059	73.28	66.6
OREGON	33,456	25,010	78.69	74.8
WASHINGTON	42,928	29,198	64.33	68.0
OUTLYING AREAS 3/	8,164	4,969	19.57	60.9

1/ BASED ON SUPPLEMENTARY MEDICAL INSURANCE ENROLLMENT AS OF JULY 1, 1983.
2/ CONSISTS OF 50 STATES AND THE DISTRICT OF COLUMBIA.
3/ CONSISTS OF PUERTO RICO, VIRGIN ISLANDS, GUAM, OTHER AREAS, AND RESIDENCE UNKNOWN.

TABLE 5

USE OF MEDICARE HOSPITAL OUTPATIENT SERVICES BY THE DISABLED EXCLUDING END-STAGE RENAL DISEASE: COVERED CHARGES AND REIMBURSEMENTS, BY RESIDENCE: 1983

AREA OF RESIDENCE	COVERED CHARGES IN THOUSANDS	TOTAL REIMBURSEMENTS		
		AMOUNT IN THOUSANDS	PER ENROLLEE 1/	AS PERCENT OF CHARGES
ALL AREAS	$430,902	$296,415	$114.20	68.8
UNITED STATES 2/	428,903	295,103	115.90	68.8
NORTHEAST	130,163	83,128	150.42	63.9
NORTH CENTRAL	95,698	66,987	112.18	70.0
SOUTH	114,217	78,900	80.68	69.1
WEST	88,825	66,167	158.50	74.5
NEW ENGLAND	32,010	22,869	186.41	71.4
CONNECTICUT	6,757	4,893	182.81	72.4
MAINE	2,697	1,309	89.66	48.5
MASSACHUSETTS	18,593	13,959	253.66	75.1
NEW HAMPSHIRE	1,380	979	117.30	70.9
RHODE ISLAND	1,708	1,110	92.00	65.0
VERMONT	874	620	105.33	70.9
MIDDLE ATLANTIC	98,153	60,259	140.15	61.4
NEW JERSEY	15,858	11,515	142.69	72.6
NEW YORK	49,681	28,559	140.10	57.5
PENNSYLVANIA	32,614	20,185	138.82	61.9
EAST NORTH CENTRAL	73,000	50,836	116.79	69.6
ILLINOIS	16,442	11,827	118.03	71.9
INDIANA	7,990	5,839	99.07	73.1
MICHIGAN	23,877	15,504	146.31	64.9
OHIO	17,019	12,198	98.65	71.7
WISCONSIN	7,672	5,467	117.51	71.3
WEST NORTH CENTRAL	22,699	16,152	99.79	71.2
IOWA	3,204	2,287	86.97	71.4
KANSAS	2,957	2,188	110.73	74.0
MINNESOTA	4,397	3,156	104.12	71.8
MISSOURI	9,549	6,774	109.83	70.9
NEBRASKA	1,664	1,190	95.06	71.5
NORTH DAKOTA	671	387	74.06	57.6
SOUTH DAKOTA	256	171	28.10	66.6
SOUTH ATLANTIC	66,850	46,254	92.55	69.2
DELAWARE	1,350	766	114.76	56.7
DIST. OF COLUMBIA	1,923	1,470	243.50	76.5
FLORIDA	15,518	11,420	85.13	73.6
GEORGIA	11,945	8,256	101.88	69.1
MARYLAND	7,502	5,033	134.07	67.1
NORTH CAROLINA	9,135	6,259	74.23	68.5
SOUTH CAROLINA	5,677	3,643	76.35	64.2
VIRGINIA	9,771	7,095	111.68	72.6
WEST VIRGINIA	4,030	2,311	59.59	57.4

SEE FOOTNOTES AT END OF TABLE

TABLE 5 (CONTINUED)

USE OF MEDICARE HOSPITAL OUTPATIENT SERVICES BY THE DISABLED EXCLUDING END-STAGE RENAL DISEASE: COVERED CHARGES AND REIMBURSEMENTS, BY RESIDENCE: 1983

AREA OF RESIDENCE	COVERED CHARGES IN THOUSANDS	TOTAL REIMBURSEMENTS		
		AMOUNT IN THOUSANDS	PER ENROLLEE 1/	AS PERCENT OF CHARGES
EAST SOUTH CENTRAL	21,090	14,566	62.75	69.1
ALABAMA	5,735	4,039	68.68	70.4
KENTUCKY	4,415	3,014	50.75	68.3
MISSISSIPPI	3,774	2,593	60.06	68.7
TENNESSEE	7,166	4,920	69.54	68.7
WEST SOUTH CENTRAL	26,277	18,080	73.47	68.8
ARKANSAS	3,220	2,267	56.77	70.4
LOUISIANA	5,570	3,790	70.79	68.0
OKLAHOMA	3,667	2,315	69.49	63.1
TEXAS	13,821	9,708	81.37	70.2
MOUNTAIN	16,324	11,749	117.82	72.0
ARIZONA	5,338	3,857	126.03	72.2
COLORADO	4,243	3,048	140.13	71.8
IDAHO	1,031	750	95.36	72.8
MONTANA	884	624	79.41	70.6
NEVADA	1,502	1,051	135.41	70.0
NEW MEXICO	2,245	1,646	121.94	73.3
UTAH	880	632	80.36	71.8
WYOMING	201	141	56.10	70.4
PACIFIC	72,501	54,418	171.26	75.1
ALASKA	349	229	148.82	65.5
CALIFORNIA	62,865	47,733	193.42	75.9
HAWAII	784	510	77.54	65.1
OREGON	3,321	2,437	95.14	73.4
WASHINGTON	5,182	3,508	94.25	67.7
OUTLYING AREAS 3/	1,999	1,232	24.48	61.6

1/ BASED ON SUPPLEMENTARY MEDICAL INSURANCE ENROLLMENT AS OF JULY 1, 1983.
2/ CONSISTS OF 50 STATES AND THE DISTRICT OF COLUMBIA.
3/ CONSISTS OF PUERTO RICO, VIRGIN ISLANDS, GUAM, OTHER AREAS, AND RESIDENCE UNKNOWN.

Definition of Terms

Disabled Medicare enrollees: These enrollees consist of two groups. In the first group are persons who have been entitled to cash disability benefits for at least 24 consecutive months - Medicare Status Code (MSC #20); some of these persons have end-stage renal disease (ESRD - MSC #21). The second group consists of persons who have not been entitled to cash disability benefits for 24 consecutive months. They are entitled to Medicare because they have ESRD and meet certain social security insured status requirements (MSC #31).

Hospital outpatient services (HOP): HOP benefits include diagnostic and therapeutic services. Diagnostic services are supplied by nurses, psychologists. and technicians who perform tests or examinations to determine medical conditions and identify disease. Drugs, supplies, and equipment related to the tests are also covered under HOP. Therapeutic services are those that aid physicians in treating patients and must pertain to physician services. Services include the use of hospital facilities such as clinic and emergency rooms, the services of various hospital personnel, speech and physical therapy services, and medical supplies and devices.

Sources and Limitations of Data

The hospital outpatient data in this report were derived from a 5 percent sample of persons enrolled for supplementary medical insurance (SMI). Sample counts were multiplied by 20 to estimate the totals. Data for 1983 were taken from bills for services performed in hospital outpatient departments during that year and tabulated by the Health Care Financing Administration's central records as of July 1, 1984. It is estimated that these bills represent about 98 percent of the eventual reimbursements for hospital outpatient services in 1983. Data for the years 1974-1982 were based on bills recorded 12 months following the year of service. Payments for hospital outpatient services shown in this report are based on interim rates that may be adjusted after the end of the hospital's accounting year based on reasonable costs of operation. The hospital outpatient figures shown reflect users of covered services whether or not they were reimbursed by the Medicare program.